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Health Homes Serving Children

Updates on Readiness and Implementation Activities

August 24, 2016

Agenda for Today's Presentation

- ✓ Timeline for Enrollment
- ✓ Updates on the Status of Readiness Activities of Contingently Designated Health Homes Serving Children, Care Managers and Plans
- ✓ Moving from Contingently Designated to Designated Health Homes Serving Children
- ✓ Health Home Serving Children Eligibility Criteria
- ✓ Documentation of Eligibility and Appropriateness (Includes Quarterly reviews)
- ✓ High, Medium Low Algorithm and Health Home Serving Children Standards
- ✓ Overview of the MAPP Health Home Tracking System (HHTS) and the Uniform Assessment System (UAS-NY)
- ✓ Questions and Discussion



December 2016 Begin Enrolling Children in Health Homes

- Health Homes Designated to Serve Children will begin to enroll children December 2016
- The enrollment date was recently changed to December 2016 to align the effective date of changes in Health Home payment methodology that will address significant delays in the time it takes payments to flow to care management agencies
- Beginning in October 2016, the following Health Home Providers may have access to the CANS-NY tool within the UAS-NY prior to December
 - OMH TCM providers will have access to UAS-NY to begin pre-populating CANS-NY for children they currently serve
 - Certain VFCA in New York City that are required to have CANS-NY that is identical to the CANS-NY for HH may begin to pre-populate CANS-NY for children that are eligible for Health Home
- ***These providers MUST have an HCS account by the first week of September to begin to access the UAS-NY CANS-NY and they must also be trained and certified in the CANS-NY assessment tool***
- Further guidance will be given to these specific providers regarding prior access to the UAS-NY
- All other providers will have access to the CANS-NY Assessment tool in December 2016



Enrolling Early Intervention Children in Health Home March 2017

- The proposed approach for having the Health Home Care Manager serve as the Ongoing Service Coordinator for children enrolled in both Health Homes and the Early Intervention Program has been approved by CMS
 - The State Health Home and Early Intervention staff have been meeting regularly to identify the methods to integrate HH services with Early Intervention Ongoing Service Coordination and to provide trainings
 - The State expects this work will be complete in 2017 and children that are eligible for Early Intervention and Health Home can be enrolled in Health Home beginning in March 2017
 - In December, children that are Health Home eligible and would be eligible for Early Intervention, should be referred to Early Intervention Services as they will receive the expertise of Early Intervention service providers inclusive of Service Coordination (i.e. Care Management)
 - Children who are receiving Early Intervention Services and Child Welfare Services as of December 2016 will not be eligible for Health Home Services at this time



Prioritizing the Enrollment of Eligible Children in Health Homes December 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children ***that meet Health Home chronic condition eligibility and appropriateness criteria*** and have the highest needs, including the following:
 - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
 - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning
 - ✓ Children on TCM waitlist; [SPOA who refers to HH]
 - ✓ Children who are on the Bridges to Health (B2H) Wait list,
 - ✓ Children in licensed congregate care,
 - ✓ Children that are within 3 months of foster care discharge,
 - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
 - ✓ Children prescribed 3 or more psychotropic medications
 - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
 - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
 - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
 - ✓ Children with multiple system involvement (child welfare, criminal justice)
- ❖ ***Children in Early Intervention target date to be enrolled March 2017 (when procedures for integrating EI and HH requirements have been established, with stakeholder feedback, and trainings provided).***



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Updates on the Status of Readiness Activities of Contingently Designated Health Homes Serving Children, Care Managers and Plans

August 24, 2016

Overview of Readiness Activities of Contingently Designated Health Homes Serving Children

- The State continues to conduct at least monthly calls with HHSC to assess progress made in addressing contingencies and overall readiness
 - ✓ State has scheduled a site visit in September for the three new Health Homes Serving Children that currently do not serve adults
- For most HHSC, outstanding readiness activities primarily revolve around:
 - ✓ ***Entering into Administrative Services Agreements (ASAs) with Managed Care Plans***
 - ✓ HIT Compliance – Updated written HIT policies, care management software
 - ✓ Billing Readiness – Billing software, Billing Certifications (adult and children Health Homes must submit separate attestations)
 - ✓ BAAs – Network Adequacy being reviewed now by State Partners, including alignment of existing waiver, OMH TCM and voluntary foster care agencies with Health Homes
 - Care At Home I & II (CAH I & II) providers
 - OMH TCM providers that will transition to Health Homes
 - Voluntary Foster Care Agencies that will be care managers for children that may be eligible for and enrolled in HH and also in foster care
 - Early Intervention (EI) providers, in preparation for March 2017 enrollment of Early Intervention and Health Home eligible children



Administrative Service Agreements (ASA) with Managed Care Plans (MCP)

- Administrative Service Agreements (revised as January 2016) with Managed Care Plans
 - Due date for entering into revised ASAs for Health Homes that now serve adults was July 1, 2016
- *ASAs are critical to ensuring there is alignment with enrolled members, Health Homes and Plans in the MAPP portal and there is adequate access to Health Homes to eligible children across the State – Only 4 of 19 Plans have entered into ASAs with Health Homes Serving Children*
- Plans should work with Health Homes now to sign January 2016 (or customized) ASAs
 - The January 2016 ASA is the appropriate ASA for Children and Adult Health Homes
 - If the MCP has a signed January 2016 ASA with an adult Health Home that is also a Health Home Serving Children no separate ASA is required
- State will be working with Health Homes, Plans, and Plan Associations to follow up on status of ASAs



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Note: Amendments in Section 6.2 states: “Amendments required due to changes in state law or regulation or as required by NYSDOH and implemented by MCO shall be unilaterally and automatically made upon thirty (30) days notice to Health Home. *There is no need to delay or to wait for revised ASA or model contract to enter into ASAs with Health Homes serving children*”



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Health Home Network Partner List Requirements

- Health Homes must re-submit Network Partner Lists by **AUGUST 31, 2016**
 - Information is used to develop “loyalty” algorithms (member connectivity to providers to help align Health Home assignment with member connection to providers for ground up referrals)
- Network Partner lists must include CMAs, non-CMA providers, and your own organization
- For non-CMA network providers, lead Health Homes must submit supporting documentation demonstrating it has a meaningful relationship with each provider listed in its network as indicated in guidance issued to Lead Health Homes on August 12, 2016
- For CMAs, submission of Business Association Agreements in your network is sufficient – additional supporting documentation is not required
- Once Health Homes have access to MAPP in December 2016, Health Homes will be able to manage their own Network Partner List by adding and deleting to the List within MAPP
- Each Health Home is responsible for maintaining supporting documentation as required by the August Guidance



Check List of Network Readiness Activities by Health Homes (**Updated as of 8/22/16**)

HH	Total CMA Partnerships	OMH TCM/BAAAs	VFCA/BAAAs	CAH/BAAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Adirondack Health Institute, Inc.	33 CMAs/33 BAAs	5 Identified TCM/5 BAAs	5 Identified/ 5 BAAs	1 Identified/ 1 BAAs	CDPHP Fidelis United Healthcare MVP Health Plan	YES
Catholic Charities of Broome County	78 CMA/78 BAAs	23 Identified TCM/ 23 BAAs	14 Identified/14 BAAs	3 Identified/ 3 BAAs	CDPHP Excellus BlueCross BlueShield HealthNow Independent Health Association MVP Health Plan Total Care UnitedHealthcare Univera Community Health Wellcare of NY	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAAAs	VFCA/BAAAs	CAH/BAAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Children's Health Home of Upstate New York	141 CMAs/128	44 Identified TCM/40 BAAAs	43 Identified/ 40BAAAs	8 Identified/ 7 BAAAs	Affinity Health Plan CDPHP Excellus BlueCross BlueShield HealthNow HealthNow Health Plus Amerigroup Independent Health Association MVP Health Plan Total Care UnitedHealthcare Univera Community Health Wellcare of NY	YES
CNYHHN, Inc	39 CMAs/32BAAAs	8 Identified TCM/ 7BAAAs	9 Identified/ 7 BAAAs	1 Identified/1 BAAAs	CDPHP Excellus BlueCross BlueShield UnitedHealthcare Wellcare of NY	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAAs	VFCA/BAAs	CAH/BAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Community Care Management Partners, LLC., (CCMP) - VNS	15 CMAs/15 BAAs	3 Identified TCM/3 BAAs	3 Identified/ 3 BAA	0 Identified/0 BAAs	Affinity Health Plan AmidaCare EmblemHealth Inc. Healthfirst PHSP, Inc. Health Plus Amerigroup MetroPlus Health Plan UnitedHealthcare VNS Choice Wellcare of NY	YES
Coordinated Behavioral Care, Inc.	32 CMAs/32 BAAs	10 Identified TCM/ 10 BAAs	7 Identified/ 7 BAAs	0 Identified/0 BAAs	Affinity Health Plan AmidaCare EmblemHealth Inc. Healthfirst PHSP, Inc. Health Plus Amerigroup MetroPlus Health Plan UnitedHealthcare VNS Choice Wellcare of NY	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAAs	VFCA/BAAs	CAH/BAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Greater Rochester Health Home Network (GRHHN)	49 CMAs/34 BAAs	15 Identified TCM/ 13 BAAs	12 Identified/ 8 BAAs	3 Identified/ 0 BAAs	Excellus BlueCross BlueShield HealthNow MVP Health Plan UnitedHealthcare Univera Community Health	YES
Hudson River HealthCare (HRHCare)	34 CMAs/34 BAAs	11 Identified TCM/ 11 BAAs	2 Identified/2 BAAs	3 Identified/3 BAAs	Affinity Health Plan CDPHP EmblemHealth Inc. Health Plus Amerigroup MVP Health Plan UnitedHealthcare Wellcare of NY	YES
Institute for Family Health (IFH)	7 CMAs/5 BAAs	0 Identified TCM/ 0 BAAs	4 Identified/ 2 BAA	0 Identified/0 BAAs	Fidelis MVP Health Plan UnitedHealthcare Wellcare of NY	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAAs	VFCA/BAAs	CAH/BAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Kaleida Health (CHHWNY)	42 CMAs/ 42 BAAs	12 Identified TCM/ 12 BAAs	10 Identified/ 10 BAAs	1 Identified/1 BAAs	Fidelis HealthNow Independent Health Association MVP Health Plan UnitedHealthcare Univera Community Health	YES
Montefiore Medical Center (BAHN)	9 CMAs/ 8 BAAs	1 Identified TCM/ 0 BAAs	0 Identified/0 BAAs	0 Identified/ 0 BAAs	Affinity Health Plan AmidaCare EmblemHealth Inc. Fidelis Healthfirst PHSP, Inc. Health Plus Amerigroup MetroPlus Health Plan UnitedHealthcare VNS Choice Wellcare of NY	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAA's	VFCA/BAA's	CAH/BAA's	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Mount Sinai Health Home Serving Children	28 CMAs/ 23 BAA's	12 Identified TCM/ 9 BAA's	8 Identified/ 5 BAA's	1 CAH/ 1 BAA's	Affinity Health Plan AmidaCare EmblemHealth Inc. Fidelis Healthfirst PHSP, Inc. Health Plus Amerigroup MetroPlus Health Plan MetroPlus Partnership in Care UnitedHealthcare VNS Choice Wellcare of NY	YES
Niagara Falls Memorial Medical Center	10 CMAs/9 BAA's	3 Identified TCM/3 BAA's	8 Identified/ 8 BAA's	0 Identified/ 0 BAA's	Fidelis Independent Health Association UnitedHealthcare	YES

Check List of Network Readiness Activities by Health Homes (Updated as of 8/22/16)

HH	Total CMA Partnerships	OMH TCM/BAAs	VFCA/BAAs	CAH/BAAs	MCO ASAs (Plan in RED has Jan. amended ASA with HHSC)	Billing Readiness Attestation
Northwell	16 CMAs/ 10 BAAs	1 Identified TCM/ 1 BAAs	1 Identified/ 1 BAAs	0 Identified/ 0 BAAs	Affinity Health Plan AmidaCare EmblemHealth Inc. Fidelis Healthfirst PHSP, Inc. Health Plus Amerigroup MetroPlus Health Plan MetroPlus Partnership in Care UnitedHealthcare VNS Choice Wellcare of NY	YES
St. Mary's Healthcare	9 CMAs/9 BAAs	1 Identified TCM/ 1 BAAs	4 Identified/ 4 BAAs	1 identified/ 1 BAA	CDPHP Fidelis UnitedHealthcare	YES
The Collaborative for Children and Families, Inc.	51 CMAs/ 51 BAAs	10 Identified TCM/ 10 BAAs	30 Identified/ 30 BAAs	2 Identified/2 BAAs	Affinity Health Plan AmidaCare EmblemHealth Inc. HealthFirst PHSP, Inc. Health Plus Amerigroup MVP Health Plan MetroPlus Health Plan MetroPlus Partnership in Care UnitedHealthcare VNS Choice Wellcare of NY	YES

Health Home Start Up Funds

- Health Home Start Up Funds of \$7.2 million for Health Homes Serving Children – those that have not received Health Home Development Funds and that have *significantly* expanded service area
- Four Health Homes meet this criteria – payments making their way through approval and processing



Moving from Contingently Designated to Designated Health Homes Serving Children



Steps Towards Designation

- Site visits in September 2016 for the 3 NEW Health Homes Serving Children
- Utilizing that Adult Health Home Re-designation Site Visits to assist with review of the 13 Health Homes that will be serving children and adults
- Monthly Check-in calls to review progress on concrete Health Home deliverables of MMIS ID #, BAAs, ASAs and Network Adequacy
- Readiness Tool that highlights the areas of capacity, training, policies and procedures, etc. for Health Homes and network partners.



Designation Process

- Review of Site and Re-designation Visits
 - Review of Deliverables
 - Review of Readiness activities development and progress
 - Review of Implemented changes directed by DOH, if applicable
- ❖ *State will begin to issue Designation to Lead Health Homes that addressed contingencies and have demonstrated they have satisfied readiness activities in October 2016*



Health Home Serving Children Eligibility Criteria



Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll in a Health Home **must** have:
 - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*)
OR
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)
- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc.) does not alone/automatically make a child eligible for Health Home
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



Serious Emotional Disturbance (SED) as a Single Qualifying Condition for Health Homes

- The DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)
- Gender Dysphoria has been added to the Health Home Serving Children SED definition
- The following slide outlines the specific Health Home Serving Children definition of SED



SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- **Gender Dysphoria**
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD for children who have utilized any of the following services in the past three years:
 - Psychiatric inpatient
 - Residential Treatment Facility
 - Day treatment
 - Community residence
 - Mental Health HCBS & OCFS B2H Waiver
 - OMH Targeted Case Management

*Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖ *Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*



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Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



Documenting Chronic Conditions Health Home Eligibility Criteria

- For eligibility chronic conditions, other than Complex Trauma, care managers are required to document eligibility for Health Home that is based on chronic conditions (e.g., DSM-V- SED, and other diagnoses of chronic conditions) by including in the care management record appropriate diagnoses made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice
- For Complex Trauma, care managers are required to document eligibility for Health Home that is based upon the outlined process and tools by including them in the care management record
- Additionally, Health Home Appropriateness needs to be reviewed and documented
- NOTE: CANS-NY tool by itself does not determine HH eligibility
- NOTE: Multiple Eligibility Reasons can be chosen



Quarterly Review Documenting Continued Need for Health Home Services

- No less than quarterly, care managers must actively review and document in the plan of care, the child's continued need for Health Home Care Management services
- Quarterly reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes:
 - The child no longer needs the intense level of care management services provided by the Health Home. Discharge planning will begin when one or more of the following exists:
 - ✓The chronic condition(s) that made the child eligible for Health Homes are being managed and or maintained,
 - ✓All parties concur the child has met the goals of his/her Plan and is stable enough to no longer require the services of a Health Home care management,
 - ✓Has service and support needs that can be met by family/guardian and services without the intensive level of HH care management
 - The Care Manager can and should review if the child needs the intense level of care management provided by a Health Home regardless of the acuity used to determine HH PMPM rate (High, Medium, Low)
 - The CANS-NY can assist with the development of the plan of care, however it does not determine when a child is discharged from a Health Home (e.g. a child with a CANS-NY medium acuity can be discharged)



Children's Health Homes Eligibility

This document is to ensure that a Care Manager has gathered the necessary documentation to indicate that the child meets Health Home eligibility and appropriateness criteria to enter Health Homes.

Date: _____

Child's Name: _____

Date of Birth: _____

Eligibility for Children's Health Homes: *Please check appropriate boxes*

- The child is enrolled in Medicaid
Medicaid CIN #: _____
- The child has two or more chronic conditions
Please list chronic conditions and *attach documentation providing diagnoses*:

- The child has one single qualifying chronic condition
 - HIV/AIDS
**please attach documentation from a medical or social work provider indicating HIV status, date of diagnosis, most recent viral load count and most recent CD4 count.*
 - Serious Emotional Disturbance-SED
**please attach documentation providing diagnosis*

Please list condition(s): _____

- Complex Trauma
**non-licensed professional please attach Cover Sheet, CT Exposure Screen, Consent and other/additional background information or supporting materials. Licensed behavioral health professional please attach CT Exposure Assessment Form, Functional Impairment Assessment, CT Eligibility Determination Form and other/additional background information or supporting materials.*

Appropriateness Criteria: *Please check appropriate box/boxes*

- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Has inadequate social/family/housing support, or serious disruptions in family relationships;
- Has inadequate connectivity with healthcare system;
- Does not adhere to treatments or has difficulty managing medications;
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- Has deficits in activities of daily living, learning or cognition issues, or
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

Documentation Health Home Eligibility and Appropriateness

Template Example



Children's Health Home Eligibility
Quarterly Review

This document is to confirm that a child continues to meet Health Home eligibility and appropriateness criteria.

Child's Name: _____

Date of Birth: _____

Eligibility for Children's Health Homes: *Please check appropriate boxes*

The child is enrolled in Medicaid

Medicaid CIN #: _____

The child has two or more chronic conditions.

Please list chronic conditions:

The child has one single qualifying chronic condition

HIV/AIDS

Serious Emotional Disturbance-SED

Complex Trauma

Appropriateness Criteria: *Please check appropriate box/boxes*

At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)

Has inadequate social/family/housing support, or serious disruptions in family relationships;

Has inadequate connectivity with healthcare system;

Does not adhere to treatments or has difficulty managing medications;

Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;

Has deficits in activities of daily living, learning or cognition issues, or

Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

Documentation of Continued need for Health Home Care Management services:

Documentation Health Home Eligibility Quarterly Review

Template Example



Complex Trauma – Single Qualifying Condition for Health Home

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

Definition of Complex Trauma

- a. The term complex trauma incorporates at least:
 - i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
 - ii. the wide-ranging, long-term impact of this exposure.
- b. Nature of the traumatic events:
 - i. often is severe and pervasive, such as abuse or profound neglect;
 - ii. usually begins early in life;
 - iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
 - iv. often occur in the context of the child's relationship with a caregiver; and
 - v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- d. Wide-ranging, long-term adverse effects can include impairments in:
 - i. physiological responses and related neurodevelopment,
 - ii. emotional responses,
 - iii. cognitive processes including the ability to think, learn, and concentrate,
 - iv. impulse control and other self-regulating behavior,
 - v. self-image, and
 - vi. relationships with others.



Complex Trauma – Eligibility Tools and Process Finalized

- Eligibility tools and process for determining and operationalizing Complex Trauma in Health Home was developed by a Work Group of trauma informed care experts and stakeholder input
- SAMSHA/CMS have reviewed the tools and process and provided some suggestions to assist with improving the Tools
 - The Stakeholder work group discussed the suggestions and made some modest edits to some of the language included in the tools
 - Department is working with Work Group to finalize changes and post to the Website
- DOH is working to try to develop training for Complex Trauma and Health Homes including:
 - Process and tools for assessing Complex Trauma
 - How to work with children who have Complex Trauma within the Health Home Care Management
 - Development of the Plan of Care

Complex Trauma Final Eligibility Tools and Documents

1. Complex Trauma Exposure Screen Form and Referral Cover Sheet – Completed by non-licensed professional or licensed professional
2. Complex Trauma Exposure Assessment Form – Must be completed by Licensed Professional
3. Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools - Must be completed by Licensed Professional
4. Complex Trauma Eligibility Determination Form - Must be completed by Licensed Professional
5. Other family and child history and information obtained – Gathered and obtained by non-licensed professional or the assessing licensed professional

Stakeholders will be notified when Final Forms will be posted to website

See Appendix here in for Work Flow Process for Complex Trauma Eligibility

Process to Determine Health Home Complex Trauma Eligibility

Need Identified by Non-Licensed Professional or Licensed Professional w/o access to tools

- Complete the Complex Trauma Exposure Screen
- Referral Cover Sheet
- Other family and child history and information obtained
 - If positive for Complex Trauma (on Exposure Screen) – Referral can be made for HH

Eligibility determined by Licensed Professional with access to tools

- Complex Trauma Exposure Assessment Form
- Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools
- Complex Trauma Eligibility Determination Form
- Other family and child history and information obtained
 - If positive *Determination* of Complex Trauma – Referral can be made for HH and Child is Eligible for Health Home under Complex Trauma single qualifying condition



Complex Trauma Definition of “Licensed Professional”

- Licensed Masters Social Worker, LMSW
- Licensed Clinical Social Worker, LCSW
- Psychologist
- Psychiatrist
- Licensed Psychiatric Nurse Practitioner, LNPP,
- Licensed Marriage and Family Therapist, LMFT,
- Licensed Mental Health Counselor, LMHC
- Pediatrician/Family Medicine Physician or Internist *with specialization in Behavioral Health*

Clinicians identified include but are not limited to employees of Licensed/Certified Article 28, 31, 32, 16 clinics.

Psychologists/Psychiatrists etc do not need to be identified as licensed as they are not professionally allowed to use the ‘label’ without appropriate licensure.



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High, Medium, Low Algorithm and Health Home Serving Children Standards



Algorithm for High, Medium and Low Health Home Serving Children Rates

- Stakeholders have requested CANS-NY Health Home rate acuity algorithms
- State is now finalizing programming of CANS-NY algorithms that determine Health Home rate acuity (High, Medium, Low)
- Algorithms anticipated to be released in early September
- State will monitor acuity determinations against supporting documentation and services included in care plan



Health Home Serving Children Standards

- Health Home Serving Children Standards have been reviewed with Stakeholder for Feedback
 - Four new implementation protocols have been added based upon stakeholder and State partner feedback and review of HH adults standards
- These Standards are being incorporated within the Health Home Standards document used within the Health Home Serving Adults – One Standards Document
 - Standards applicable to just children or adults are identified



Health Home Serving Children Standards – Review of Current Standards Developed in Previous Webinars with Stakeholder Feedback

- 1) HH to ensure all Care Managers/Supervisors receive required trainings (initial and within six months, including CANS-NY)
- 2) HH to tailor delivery of services to children and ensure the Six Core Services
- 3) HH to meet staff qualifications for the Care Manager serving children
- 4) HH supervisor to Care Management ratio of CMAs
- 5) HH will ensure child's eligibility and Plan of Care are monitored/reviewed minimally quarterly and disenrollment criteria are reviewed – Supporting Documentation needs to be present within the case record
- 6) HH to ensure policies for interdisciplinary team meeting standards are in place
- 7) HH to ensure Plan of Care has the “10 Elements of Plans of Care”
- 8) HH to ensure consent and enrollment forms are completed for each child
- 9) HH care managers must provide two HH services per month for medium to high acuity children, one of which must be a face-to-face encounter with the child



Four New Implementation Protocols for Health Home Serving Children

- 10) HH to ensure that policies/procedures are in place for care managers to contact child/family within 48 hours of discharge from an inpatient unit, residential services, detention, ED, etc. (when they are notified or become aware) – HH care managers should be involved in the discharge planning process
- 11) If during outreach (prior to enrollment), the member (if appropriate) or the parent/guardian/legally authorized representative refuses Health Home services, then the Health Home Care Manager should contact the referent (the person who made the referral – information is included in the Health Home Referral Portal) and make them aware of such refusal of Health Home services and document such prior to closing the referral.
Reminder: A minimum of verbal consent must be given by the member (if appropriate) or the parent/guardian/legally authorized representative for a HH referral to be made in the HH Referral Portal.
- 12) For children in ACT or AOT (between 18-21), if eligible for Health Home, the Health Home type must be adult and the CMA must be an ACT provider. For children in AOT (between 18-21), if eligible for Health Home, the Health Home type must be adult in order to meet the HH plus requirements
- 13) Documentation within the case record and reflected within the POC needs to be present to support the CANS-NY ratings that determine HML for Health Homes.
 - Such documentation may be school records, psychosocial assessments, child welfare records and information, etc.



Overview of the MAPP Health Home Tracking System (HHTS) and the Uniform Assessment System (UAS-NY)



Access to MAPP: Health Homes, CMAs, MCP, LDSS' and LGU/SPOAs

- To access MAPP Health Home Tracking System and the UAS-NY (for CANS-NY) all Health Homes, CMAs, MCP, LGU/SPOAs, and LDSS' must acquire access to Health Commerce System (HCS)
 - ✓ Each organization must have an organizational HCS Director and Coordinator
- Training will be held for identified **HCS Directors and Coordinators** regarding the various roles and responsibilities within MAPP and the UAS-NY
 - ✓ Once that training has occurred, organizations will then need to identify the staff who need access to MAPP and the UAS-NY and what role they should have
 - ✓ Each staff identified within the organization that will need a role in MAPP and the UAS-NY will need a HCS account prior to being able to have a role assigned to them within MAPP or the UAS-NY
- Training to specific MAPP and UAS-NY **end-users** will then be conducted
 - ✓ MAPP Training tentatively scheduled for October / November
 - ✓ UAS-NY training in September / October for organizations (OMH-TCM and NYC VFCA) who can pre-populate the CANS-NY in October
 - ✓ UAS-NY training for the rest of end-users will occur in October / November
- All correspondence regarding HCS, MAPP and UAS-NY access and training will be sent to organization's Single Point of Contact (SPOC) – Important for organizations to be aware of who their individual SPOC is and ensure that DOH has an updated SPOC when a change is made
- *Webinars have been held specifically for LDSS and LGU/SPOA regarding access – will be posted to the DOH website (These webinars can be helpful for all Health Home organizations that need access to the HCS, MAPP and UAS-NY)*



MAPP HHTS Changes and File Specifications

- Most MAPP HHTS files will be updated to include at least one field to accommodate either system enhancements or new fields for Mapp modifications made for expanding the Health Home program to serve children
- DOH will release this week an excel spreadsheet containing new file specifications for the December 1, 2016 implementation of the Health Homes serving children.
- This document will show all of the fields that will be added to the files on December 1, 2016, but some of those new fields will not be populated with values until early 2017. These fields will be highlighted in yellow.
- By early September, two new MAPP HHTS File Specifications Documents will be released:
- An updated version of the current document clarifying how the current MAPP HHTS files work and will be effective through November 30, 2016.
- A version explaining all of the December 1, 2016 file updates. This version will be release soon but will not become effective until December 1, 2016.
 - The current MAPP HHTS File Specification Document is posted to the MAPP section of the website (link below). The Health Home community will be notified when this document is updated through the Health Home listserv.
 - MAPP section of Health Home website:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm



MAPP HHTS Development: Children's Functionality

- The MAPP HHTS will be operational for Health Homes Serving Children and their Care Management Agencies in December 2016, inclusive of the Referral Portal
- The MAPP HHTS will verify if a CANS-NY tool was completed; and determine the type of CANS-NY (Initial, 6 month reassessment or early re-assessment) for Billing to occur
- MAPP HHTS Training will occur in October/November 2016



UAS-NY and the CANS-NY

- The CANS-NY tool will be operational and accessed in the UAS-NY beginning December 2016
 - OMH-TCM and certain NYC VFCA who can pre-populate the CANS-NY will have access to the UAS-NY in October (separate guidance will be provided to these providers)
 - The UAS-NY will verify through Learner Nation if the Care Manager has an active CANS-NY certification – this certification is required to access the CANS-NY within the UAS-NY
 - Annual renewal of CANS-NY certification is required to access the CANS-NY within the UAS-NY
 - If certification has lapsed, then Review Only Access will be available
- The UAS-NY will transmit specific CANS-NY information to MAPP HHTS for Billing to occur
- UAS-NY Training will occur in October / November 2016 for non-pre-populations organizations



Recent Webinars – Contain Information that Respond to Frequently Asked Questions



Recent Webinars

- June 8 & 21, 2016 – Complex Trauma
- June 29, 2016 - Billing Guidance
- July 13 & 27, 2016 - MAPP Children's HH Referral Portal
- August 17, 2016 - Consent Process, Forms and Guidance

- Health Home Serving Children webinar link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm



What Topics Would Help You

- Due to the enrollment timeline change to December 2016, DOH and our State Partners will be updating the webinar training schedule
- What topics would be most helpful to you and your organization?
 - Please email us at Health Homes Serving Children to:
hhsc@health.ny.gov



Questions and Discussion



Subscribe to the HH Listserv

- Stay up-to-date by signing up to receive Health Home e-mail updates
- Subscribe
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Health Homes Serving Children List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit



Health Homes Serving Children List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency



APPENDIX

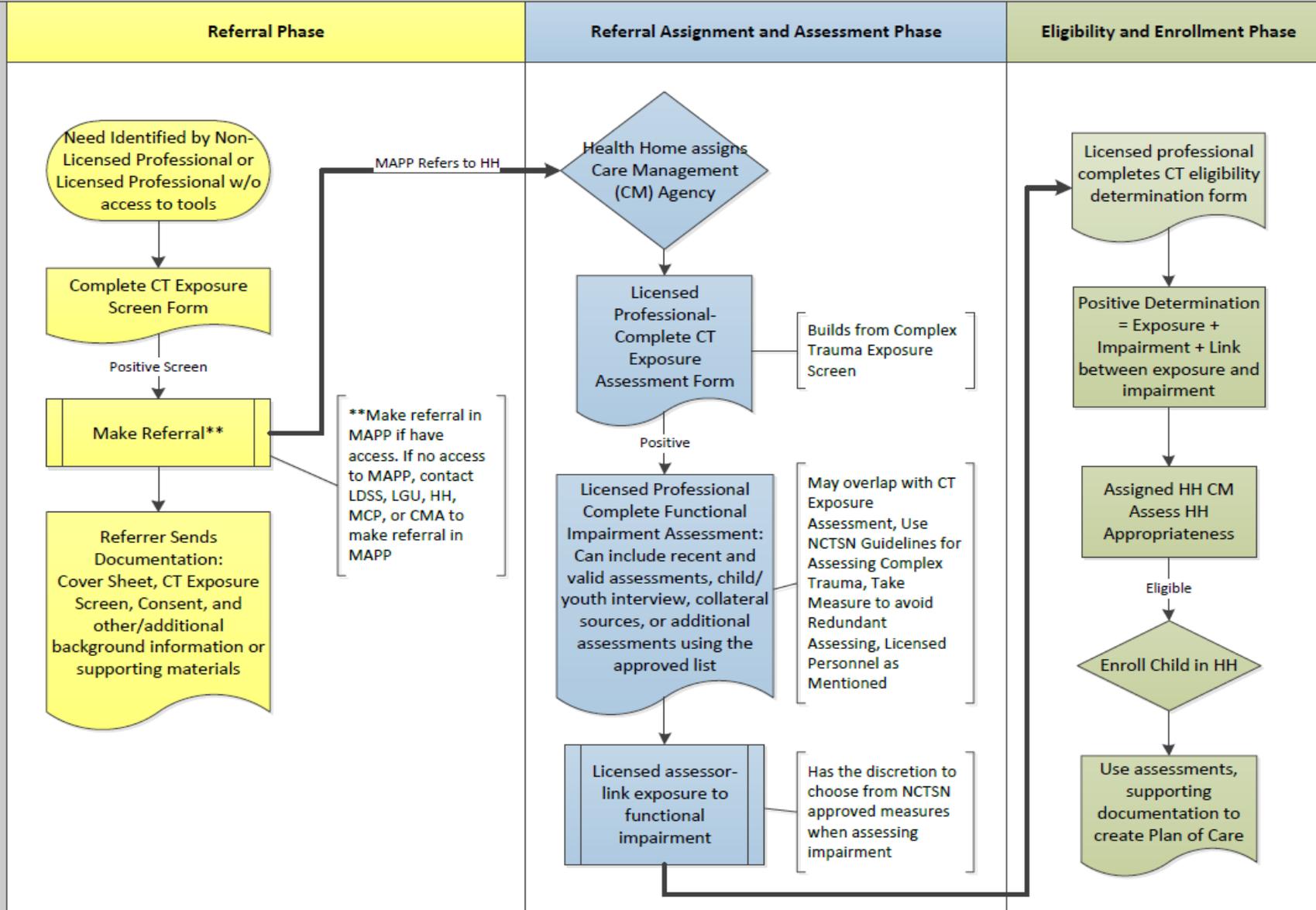


Department
of Health

Office of
Mental Health

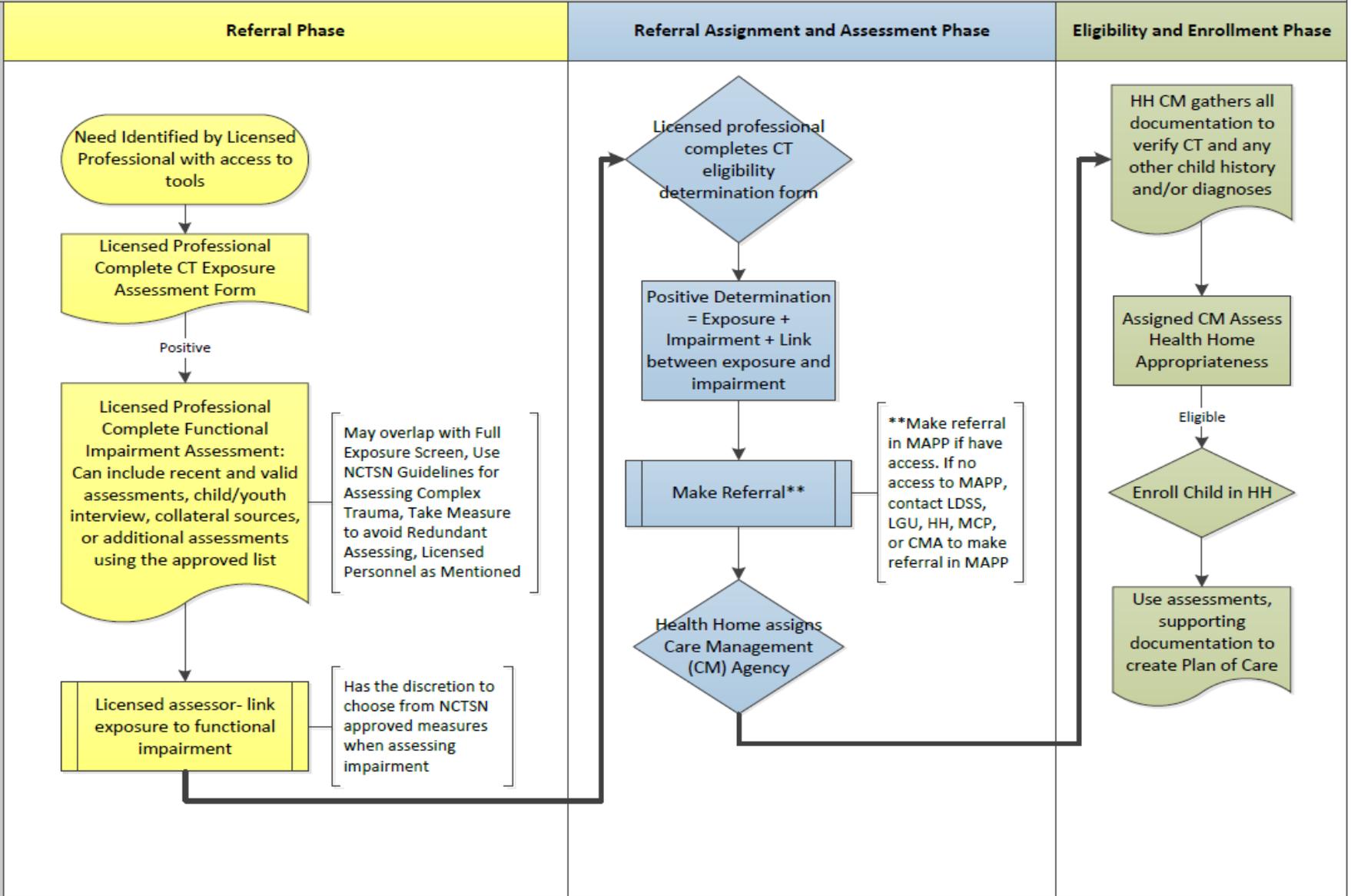
Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services



Workflow Process – Scenario #1





Workflow Process – Scenario #2



Examples of Billable Services Provided Under Each Health Home Core Service

1. Comprehensive Care Management

- A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

2. Care Coordination and Health Promotion

- The Health Home provider is accountable for engaging and retaining Health Home members in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.



Examples of Billable Services Provided Under Each Health Home Core Service

3. Comprehensive Transitional Care

- The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

4. Patient and Family Support

- Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

5. Referral to Community Supports

- The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

10 Elements to be Included in all Plans of Care for Children

- For all children enrolled in a Health Home, the plan of care (POC) must include the following specific elements and be consistent with the requirements of the six core services:
 - 1) The child's **Emergency Contact and disaster plan** for fire, health, safety issues, natural disaster, other public emergency.
 - 2) The child's **History and Risk Factors** related to services and treatment, well-being and recovery.
 - 3) The child's **Functional Needs** related to services and treatment, well-being and recovery.
 - 4) The child's and caregivers' identified **Strengths and Preferences** related to services and treatment, well-being and recovery.
 - 5) *Medicaid State Plan and Non-Medicaid services identified to meet child's needs – must be person-centered, comprehensive and integrated to include Physical, Behavioral Community and Social Supports. Plan must also document the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.*



Elements to be Included in all Plans of Care for Children - Continued

- 6) Key Informal **Community Supports**. This would include any supports in place for the child/family that address identified needs (Ex. Family's neighbor is available for support as needed and is aware of child/family's needs, but is not assigned a specific task to reach a goal).
- 7) Description of planned **Care Management Interventions** (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timeframes.
- 8) The child's **Transition Plan** including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care)
- 9) Documentation of participation by **inter-disciplinary team** (all Key Providers) in the development of the plan of care.
- 10) The **Child's Medical consentor's Signature** documenting agreement with the plan of care. (referencing *DOH 5201* Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age)

